

## RELATIONSHIP DNA TEST SUBMISSION FORM

|   |                                |                             |   |                     |
|---|--------------------------------|-----------------------------|---|---------------------|
| Please complete this form and email, fax or mail to the contact indicated above.<br>A customer service associate will arrange any necessary appointments. Please note, shaded areas are for WFG use only. |                                |                             |   |                     |
| <b>Submission Date:</b>   | <b>Submitter Name:</b>         | <b>Submitter Telephone:</b> | <b>Submitter Email:</b>   |                     |
| <b>Agency (eg: Embassy, Consulate or CIC Office)</b>  |                                | <b>Agency File #</b>        | <b>Wfg #:</b>   |                     |
| <b>DNA TEST REQUIRED:</b>   |                                |                             |   |                     |
| <input type="checkbox"/> Paternity <input type="checkbox"/> Maternity <input type="checkbox"/> Sibling <input type="checkbox"/> Half Sibling <input type="checkbox"/> Other: _____                        |                                |                             |   |                     |
| <b>DONOR #1 INFORMATION</b>   |                                |                             |   |                     |
| <b>First Name:</b>  | <b>Middle Name:</b>            | <b>Last Name:</b>           | <b>Sex:</b><br><input type="checkbox"/> Male<br><input type="checkbox"/> Female |                     |
| <b>Role:</b>  |                                |                             |   |                     |
| <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Child <input type="checkbox"/> Other (please specify) _____  |                                |                             |   |                     |
| <b>Birth Date: (yyyy/mm/dd)</b>   | <b>Street Address:</b>         |                             |   |                     |
| <b>P.O. Box:</b>  | <b>City:</b>                   | <b>Province:</b>            | <b>Country:</b>   | <b>Postal Code:</b> |
| <b>Email Address:</b>   | <b>Additional Information:</b> |                             | <b>Telephone no.:</b>   |                     |
| <b>Wfg use only:</b>  | <b>Item # :</b>                | <b>Date:</b>                | <b>Processed by:</b>  |                     |
| <b>Comments:</b>  |                                |                             |   |                     |

|  |                                |                   |   |                     |
|--|--------------------------------|-------------------|---|---------------------|
| <b>DONOR #2 INFORMATION</b>  |                                |                   |   |                     |
| <b>First Name:</b>   | <b>Middle Name:</b>            | <b>Last Name:</b> | <b>Sex:</b><br><input type="checkbox"/> Male<br><input type="checkbox"/> Female |                     |
| <b>Role:</b>   |                                |                   |   |                     |
| <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Child <input type="checkbox"/> Other (please specify) _____ |                                |                   |   |                     |
| <b>Birth Date: (yyyy/mm/dd)</b>  | <b>Street Address:</b>         |                   |   |                     |
| <b>P.O. Box:</b>   | <b>City:</b>                   | <b>Province:</b>  | <b>Country:</b>   | <b>Postal Code:</b> |
| <b>Email Address:</b>  | <b>Additional Information:</b> |                   | <b>Telephone no.:</b>   |                     |
| <b>Wfg use only:</b>   | <b>Item # :</b>                | <b>Date:</b>      | <b>Processed by:</b>  |                     |
| <b>Comments:</b>   |                                |                   |   |                     |

| DONOR #3 INFORMATION  |          |                         |               |            |  |
|---|----------|-------------------------|---------------|------------|--|
| First Name:   |          | Middle Name:            |               | Last Name: |  |
|   |          |                         |               |            | Sex:<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female |
| Role:<br><input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Child <input type="checkbox"/> Other (please specify) _____ |          |                         |               |            |  |
| Birth Date: (yyyy/mm/dd)  |          | Street Address:         |               |            |  |
| P.O. Box:   |          | City:                   | Province:     | Country:   | Postal Code:   |
| Email Address:  |          | Additional Information: |               |            | Telephone no.:   |
| <b>Wfg use only:</b>  | Item # : | Date:                   | Processed by: |            |  |
| Comments:   |          |                         |               |            |  |

| DONOR #4 INFORMATION<br>(PLEASE USE A SECOND FORM IF ADDITIONAL DONORS)   |          |                         |               |            |  |
|---|----------|-------------------------|---------------|------------|--|
| First Name:   |          | Middle Name:            |               | Last Name: |  |
|   |          |                         |               |            | Sex:<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female |
| Role:<br><input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Child <input type="checkbox"/> Other (please specify) _____ |          |                         |               |            |  |
| Birth Date: (yyyy/mm/dd)  |          | Street Address:         |               |            |  |
| P.O. Box:   |          | City:                   | Province:     | Country:   | Postal Code:   |
| Email Address:  |          | Additional Information: |               |            | Telephone no.:   |
| <b>Wfg use only:</b>  | Item # : | Date:                   | Processed by: |            |  |
| Comments:   |          |                         |               |            |  |

| THE SUBMITTER AUTHORIZES WFG TO SEND A COPY OF THE REPORT TO:<br>REPORT RECIPIENT(S) |        |
|--|--------|
| Name:  | Email: |
| Name:  | Email: |

| PAYMENT INFORMATION:  |
|---|
| <input type="checkbox"/> Certified cheque or money order payable to Wyndham forensic group<br><input type="checkbox"/> Wire transfer (Must include CIC File # and Wfg File#)<br><input type="checkbox"/> Transfer by email to admin@wyndhamforensic.ca (Must include CIC File # and Wfg File #)<br><input type="checkbox"/> Pay with credit card – through Wfg issued Invoice |
| <p><b>* An administrative fee will apply if this case is cancelled at any time prior to testing.</b></p>  |